UTEA : Appendix A
Technical Unit - List of Classes

Aircraft Pilot-E	E12
Aircraft Pilot-A	13
Aviation Communication Technician-E	9
Aviation Communication Technician-E	10
Aviation Communication Technician-E	E11
Aviation Communication Technician-A	12
Construction Aide (Trnsp)-E	6
Construction Aide (Trnsp)-E	E7
Construction Technician (Trnsp)-E	8
Construction Technician (Trnsp)-E	9
Construction Technician (Trnsp)-E	E10
Construction Technician (Trnsp)-A	11
Construction Technician (Trnsp)-2A	12
Dental Hygienist	E11
Dental Lab Technician-E	8
Dental Lab Technician-E	9
Dental Lab Technician-E	E10
Dental Lab Technician-A	11
Dental Lab Technician-SS	12
Drafting Assistant-E	6
Drafting Assistant-E	7
Drafting Assistant-E	E8
Drafting Technician-E	8
Drafting Technician-E	9
Drafting Technician-E	E10
Drafting Technician-A	11
Drafting Technician-SS	12
EEG/EKG Assistant-E	6
EEG/EKG Assistant-E	7
EEG/EKG Assistant-E	E8
Engineering Assistant-E	6
Engineering Assistant-E	7
Engineering Assistant-E	E8
Engineering Assistant-A	9
Engineering Technician-E	8
Engineering Technician-E	9
Engineering Technician-E	E10
Engineering Technician-A	11
Engineering Technician-SS	12
Environmental Technician-E	8
Environmental Technician-E	9
Environmental Technician-E	E10
Environmental Technician-A	11
Environmental Technician-SS	12

Equipment Technician-E	8
Equipment Technician-E	9
Equipment Technician-E	E10
Equipment Technician-A	11
Equipment Technician-SS	12
Fingerprint Technician-E	7
Fingerprint Technician-E	8
Fingerprint Technician-E	E9
Fingerprint Technician-A	10
Fisheries Assistant-E	6
Fisheries Assistant-E	E7
Fisheries Assistant-*Frozen*	E8
Fisheries Technician-E	8
Fisheries Technician-E	9
Fisheries Technician-E	E10
Fisheries Technician-A	11
Forest Technician-E	8
Forest Technician-E	9
Forest Technician-E	E10
Forest Technician-A	11
Geological Technician-E	8
Geological Technician-E	9
Geological Technician-E	E10
Geological Technician-A	11
Graphic Arts Designer-E	9
Graphic Arts Designer-E	10
Graphic Arts Designer-E	E11
Graphic Arts Designer-A	12
Graphic Arts Designer-SS	13
Laboratory Assistant-E	6
Laboratory Assistant-E	7
Laboratory Assistant-E	E8
Laboratory Assistant-A	9
Laboratory Glassware Worker-E	4
Laboratory Glassware Worker-E	E5
Laboratory Glassware Worker-A	6
Laboratory Technician-E	8
Laboratory Technician-E	9
Laboratory Technician-E	E10
Laboratory Technician-A	11
Laboratory Technician-SS	12
Media Production Specialist-E	P11
Pharmacy Assistant-E	E8
Photographer-E	9
Photographer-E	10
Photographer-E	E11

Photographer-A	12
Photo Services Assistant-E	6
Photo Services Assistant-E	7
Photo Services Assistant-E	E8
Photo Services Assistant-A	9
Radio Communications Technician-E	8
Radio Communications Technician-E	9
Radio Communications Technician-E	E10
Radio Communications Technician-A	11
Radio Communications Technician-SS	12
Respiratory Therapy Technician-E	8
Respiratory Therapy Technician-E	9
Respiratory Therapy Technician-E	E10
Surveying Technician-E	8
Surveying Technician-E	9
Surveying Technician-E	E10
Surveying Technician-A	11
Traffic Technician-E	8
Traffic Technician-E	9
Traffic Technician-E	E10
Traffic Technician-A	11
Traffic Technician-SS	12
Water Quality Technician-E	8
Water Quality Technician-E	9
Water Quality Technician-E	E10
Water Quality Technician-A	11
Water Quality Technician-SS	12
Wildlife Technician-E	8
Wildlife Technician-E	9
Wildlife Technician-E	E10
Wildlife Technician-A	11
X-Ray Technician-E	8
X-Ray Technician-E	9
X-Ray Technician-E	E10
X-Ray Technician-A	11
Architectural Draftsman	10RR
Engineering Draftsman	07RR
Engineering Draftsman	09RR
Property Technician	10RR
Traffic Technician	11RR
Trns Constr Aide	07RR
Trns Constr Insptr	07RR
Trns Constr Insptr	09RR
Trns Constr Tech	07RR

Appendix B
(INSERT CURRENT APPLICATION FOR MEMBERSHIP)

Appendix C
(INSERT CURRENT REPRESENTATION SERVICE FEE FORM)

Appendix D
Departmental Layoff Units and Bumping Sequence

1. Departmental Layoff Units

In accordance with the provisions of Article 13 of this Agreement, the following represents the designated layoff units for Department/Agencies which employ members of this Unit unless altered through secondary negotiations.

A. Department of Transportation:
region, except for the Lansing area which will include the Secondary Complex and the Bureau of Aeronautics as one layoff unit.

B. Department of Natural Resources:
Statewide

C. Department of Agriculture:
County

D. Departments of State Police/Management and Budget:
County, except that Ingham and Eaton shall be one layoff unit.

E. Department of Community Health:
Agency

F. In the following Departments, layoff units shall be the geographical or organizational entity as defined in the employment preference plans on file with Civil Service unless altered through secondary negotiations.
Department of Corrections
Department of Consumer and Industry Services
Department of Civil Service
Department of Education
Unemployment Agency
Department of Military and Veterans Affairs
Department of State

2. Bumping Procedure

Employees of this Unit, if exercising their option to bump, shall do so in the sequence provided herein unless altered through secondary negotiations.

A. Department of Transportation/Management and Budget:
   (1) The employee shall have the right to first bump laterally within his/her current class/level in his/her layoff unit. If a lateral bump is unavailable within the layoff unit, the employee may bump laterally statewide.
   (2) If a lateral bump as provided in A1 above is unavailable, the employee may bump at the next and successively lower levels within his/her current class series within his/her layoff unit if available. If not, the employee may bump at the next and successively lower levels statewide.

B. Departments of Natural Resources/Community Health:
   (1) The employee shall have the right to first bump laterally in his/her current class/level within his/her layoff unit.
   (2) If a lateral bump as provided in B1 above is unavailable, the employee may bump at the next and successively lower levels within his/her current class series in the layoff unit.

C. Departments of Agriculture/State Police:
   (1) The employee shall have the right to first bump laterally in his/her current class/level within his/her layoff unit.
   (2) If a lateral bump as provided in C1 above is unavailable, the employee shall have the option of bumping at the next and successively lower levels within his/her current class series within the layoff unit.
   (3) If a bump, as provided in C2 above is unavailable the employee may bump at successively lower levels within his/her current class series statewide.

D. The bumping procedure for those Departments designated in Section 1(f) of this Appendix shall be in accordance with the employment preference plans on file with Civil Service unless altered through secondary negotiations.

3. The parties agree that an employee's bumping rights as provided in Section 2A-D above, shall only be exercised in the Bargaining Unit and only in those classifications to which the employee has served and attained Civil Service status.

Appendix E
Reassignment Expense Reimbursement for Eligible Employees

1. **Persons Covered:**

All authorized full-time employees currently employed by the State of Michigan being reassigned under Article 16, who actually move their residence closer to the new work location as a direct result of the reassignment, and who agree to continue employment in the new location for a minimum of one year are entitled to all benefits provided by this policy. New employees not presently (on the effective date of this Agreement) working for the State of Michigan shall not be entitled to benefits provided in this policy.

2. By Commercial Mover:

The State will pay the transportation charges for normal household goods up to a maximum of 14,000 pounds for each move. Charges for weight in excess of 14,000 pounds must be paid directly to the mover by the employee.

A. Household Goods: Includes all furniture, personal effects and property used in a dwelling, and normal equipment and supplies used to maintain the dwelling except automobiles, boats, camping vehicles, firewood, fence posts, toolsheds, motorcycles, snowmobiles, explosives, or property liable to impregnate or otherwise damage the mover's equipment perishable foodstuffs subject to spoilage, building materials, fuel or other similar non-household good items.
B. Packing: The State will pay up to $800 for packing and/or unpacking breakables. The employee must make arrangements and pay the mover for any additional packing required.
C. Insurance: The carrier will provide insurance against damage up to $.60 per pound for the total weight of shipment. The State will reimburse the employee for

insurance cost not to exceed an additional $.65 per pound for the total weight of the shipment.

In addition to the above packing allowances:

The State will pay the following accessorial charges which are required to facilitate the move.

A. Appliance Service;
B. Piano or organ handling charges;
C. Flight, elevator or distance carry charges;
D. Extra labor charges required to handle heavy items, i.e., pianos, organs, freezers, pool tables, etc.

Charges for stopping in transit to load or unload goods and the cost of additional mileage involved to effect a stop in transit must be paid by the employee. Also, extra labor required to expedite a shipment at the request of the employee must be paid by the employee.

3. Mobile Homes:

The State will pay the reasonable actual cost for moving a mobile home if it is the employee's domicile, plus a maximum $1,000 allowance for blocking,unblocking, securing contents or expando units, installing or removal of tires (on wheels) on or off the trailer, removal or replacement of skirting and utility connections will be paid by the State when accompanied by receipts.

"Actual moving cost" includes only the transportation cost, escort service when required by the governmental unit, special lighting permits, tolls or surcharges. "Actual moving cost " does not include the moving of oil tanks, out buildings, swingsets, etc. that cannot be dismantled and secured inside the mobile home.

Mobile home liability is limited to damage to the unit caused by negligence of the carrier, and to contents up to a value of $1,500. Additional excess valuation and/or hazard insurance may be purchased from the carrier at the expense of the employee.

The repair or replacement of equipment of the trailer, i.e., tires, axles, bearings, lights, etc, are the responsibility of the owner.

4. Storage of Household Goods:

The State will pay for storage not in excess of sixty (60) calendar days in connection with an authorized move at either origin or destination, only when housing is not readily available.

5. Temporary Travel Expense:

From effective date of reassignment, up to sixty (60) calendar days of travel expenses at the newly assigned work station are allowed. Extension beyond sixty days, but not to exceed a total of one hundred eighty (180) days, may be allowed due to unusual circumstances at the full discretion of the Employer. Authorized travel shall include one (1) round trip weekly between the new work station and the former residence.

6. To Secure Housing:

A continuing employee and one (1) additional family member will be allowed up to three (3) round trips to a new official work station for the purpose of securing housing. Travel, lodging, and food costs will be reimbursed up to a maximum of nine (9) days in accordance with the Standardized Travel Regulations.

Appendix F
Letter of Understanding
Article 26

The attached Rules for Network Use will be used by the parties in determining in-network and out-of-network benefits. In addition, the parties agree to set up a joint committee for the purpose of creating any additional guidelines and reviewing implementation. The committee will also be charged with identifying situations in which access to non-participating providers may be necessary and developing procedures to avoid balance billing in these situations.

The parties have also discussed the fact that there are some State employees who do not live in Michigan. The following are procedures in place for persons living or traveling outside Michigan:

Members who need medical care when away from Michigan can take advantage of the Third Party Administrator's National PPO program. There is a toll-free number for members to call in order to be directed to the nearest PPO provider. The member is not required to pay the physician or hospital at the time of service if he/she presents the PPO identification card to the network provider.

If a member is traveling he/she must seek services from a PPO provider. Failure to seek such services from a PPO provider will result in a member being treated as out-of-network unless the member was seeking services as the result of an emergency.

If a member resides out of state and seeks non-emergency services from a non-PPO provider, he/she will be treated as out-of-network. If there is not adequate access to a PPO provider, exceptions will be handled on a per case basis.

RULES FOR NETWORK USE

A member is considered to have access to the network based on the type of services required, if there are:

- Primary care -two primary care physicians (PCP) within 15 miles;
- Specialty care -two specialty care physicians (SCP) within 20 miles; and
- Hospital - one hospital within 25 miles.

The distance between the member and provider is the center-point of one zip code to the center-point of the other.

MEMBER COSTS ASSOCIATED WITHIN IN-NETWORK OR OUT-OF-NETWORK USE

	IN-NETWORK	**OUT-OF-NETWORK**
Deductible	$200/Individual $400/Family	$500/Individual $1,000/Family
Co-Payments	Office Visits $10 Services 0% Or 10% Emergency 0%	Most Services 10% (See 2. Below)
Preventive Services	Covered At 100% Limited To $500 Per Calendar Year Per Person. In January 2004, Limit Increases To $750.	Not Covered
Out-of-Pocket Maximum	$1,000/Individual $2,000/Family	$2,000/Individual $4,000/Family

1. If a member has access to the network, the member receives benefits at the in-network level when a network provider is used. The member is responsible for the in-network deductible (if any) and co-payment (if any). If a network provider refers the member to an out-of-network SCO the member continues to pay in-network expenses.

2. If a member has access to the network, the member receives benefits at the out-of-network level when a non-network provider is used. The member is responsible for the out-of-network deductible (if any), and co-payment (if any).

   - If the non-network provider is a Blues' participating provider, the provider will accept the Blues' payment as payment in full. The member is responsible for the out-of-network deductible and co-payment. The member will not, however, be balance billed.

   - If the non-network provider is not a blues' participating provider, the provider does not accept blues' payment as payment in full. The member is responsible for the out-of-network deductible and co-payment. The member may also be balance billed by the provider for all amounts in excess of the Blues' approved payment amount.

   When a member has access to the network and chooses to use an out-of-network provider, amounts paid toward the out-of-network deductible, co-

payment or out-of-pocket maximum cannot be used to satisfy the in-network deductible, co-payments or out-of-pocket maximum.

3. If a member does not have access to the network as provided above, the member will be treated as in-network for all benefits. The member will be responsible for the in-network deductible (if any) and co-payment (if any).

4. If a member does not have access to the network but then additional providers join the network so that the member would now be considered in-network, the member will be notified and given a reasonable amount of time in which to seek care from an in-network provider. Care received from a non-network provider after that grace period will be considered out-of-network and the out-of-network deductibles, co-payments and out-of-pocket maximums will apply. If a member is undergoing a course of treatment at the time he becomes in-network, the in-network rules will continue for that course of treatment only pursuant to the PPO standard transition policy. Once the course of treatment has been finished, the member must use an in-network provider or be governed by the out-of-network rules.

   If a member is under a course of treatment on January 1, 2003 when the new state Health Plan is implemented, the member will be treated as in-network until the course of treatment is concluded pursuant to the PPO standard transition policy. After that, the level of benefits will be governed by the in/out-of-network rules of the new State Health Plan.

Appendix G
Article 26
State Health Plan PPO – Benefit Chart

	In-Network	Out-of-Network
Preventive Services - Limited to $500 per calendar year per person (In January 2004, limit increases to $750)		
Health Maintenance Exam - includes chest X-ray, EKG and select lab procedures	Covered -100%, one per calendar year	Not covered
Annual Gynecological Exam	Covered -100%, one per calendar year	Not covered
Pap Smear Screening-laboratory services only	Covered -100%, one per calendar year	Not covered
Well-Baby and Child Care	Covered -100% -6 visits per year through age 1 -2 visits per year, age 2 through 3 -1 visit per year, age 4	Not covered

	through 15	
Immunizations (no age limit). Annual flu shot; Hepatitis C screening covered for those at risk	Covered - 100%	Not covered
Fecal Occult Blood Screening	Covered -100%, one per calendar year	Not covered
Flexible Sigmoidoscopy Exam Colonoscopy Exam	Covered - 100%	Not covered
Prostate Specific Antigen (PSA) Screening	Covered -100%, one per calendar year	Not covered
Mammography		
Mammography Screening	Covered - 100% One per calendar year, no age restrictions	Covered - 90% after deductible
Physician Office Services		
Office Visits	Covered - $10 co-pay	Covered - 90% after deductible, must be medically necessary
Outpatient and Home Visits	Covered - 100% after deductible	Covered - 90% after deductible, must be medically necessary
Office Consultations	Covered - $10 co-pay	Covered - 90% after deductible, must be medically necessary
Emergency Medical Care		
Hospital Emergency Room-approved diagnosis, prudent person rule	Covered - 100% for emergency medical illness or accidental injury	Covered - 100% for emergency medical illness or accidental injury
Ambulance Services - medically necessary for illness and injury	Covered - 100% after deductible	Covered - 100% after deductible
Diagnostic Services		
Laboratory and Pathology Tests	Covered - 100% after deductible	Covered - 90% after deductible
Diagnostic Tests and X-rays	Covered - 100% after deductible	Covered - 90% after deductible
Radiation Therapy	Covered - 100% after deductible	Covered - 90% after deductible

Maternity Services Provided by a Physician		
Pre-Natal and Post-Natal Care	Covered - 100% after deductible	Covered - 90% after deductible
	Includes care provided by a Certified Nurse Midwife	
Delivery and Nursery Care	Covered - 100% after deductible	Covered - 90% after deductible
	Includes delivery provided by a Certified Nurse Midwife	
Hospital Care		
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies, and Blood Storage	Covered - 100% after deductible Unlimited Days	Covered - 90% after deductible Unlimited Days
Inpatient Consultations	Covered - 100% after deductible	Covered - 90% after deductible
Chemotherapy	Covered - 100% after deductible	Covered - 90% after deductible
Alternatives to Hospital Care		
Skilled Nursing Care	Covered - 100% after deductible	Covered - 90% after deductible
	120 days per confinement	
Hospice Care	Covered - 100%	Covered - 100%
	Limited to the lifetime dollar maximum which is adjusted annually by the State	
Home Health Care	Covered - 100% after deductible	Covered - 100% after deductible
	Unlimited visits	
Surgical Services		
Surgery - includes related surgical services	Covered - 100% after deductible	Covered - 90% after deductible
Voluntary Sterilization	Covered - 100% after deductible	Covered - 90% after deductible
Human Organ Transplants		
Specified Organ Transplants - in designated facilities only - when coordinated through the TPA	Covered - 100% after deductible	Covered - in designated facilities only
	Up to $1 million maximum per transplant type	
Bone Marrow - when coordinated through the TPA -	Covered - 100% after deductible	Covered - 90% after deductible

specific criteria applies		
Kidney, Cornea and Skin	Covered - 100% after deductible	Covered - 90% after deductible
Mental Health Care and Substance Abuse - Covered under non-BCBSM contract		
Inpatient Mental Health	100%, up to 365 days per year. Partial Day Hospitalization at 2:1 ratio	50%, up to 365 days per year
Outpatient Mental Health Care	90% of network rates	50% of network rates
Inpatient Alcohol & Chemical Abuse Care	100% up to two 28-day admissions per calendar year, with 60 day interval. Intensive Outpatient Treatment at 2:1 ratio. Halfway House 100%	50% up to two 28-day admissions per calendar year, with 60 day interval. Intensive Outpatient Treatment at 2:1 ratio. Halfway House 50%
Outpatient Alcohol & Chemical Abuse	90% of network rates; Limit $3,500/year chemical dependency only	50% of network rates Limit $3,500/year chemical dependency only
Other Services		
Allergy Testing and Therapy	Covered - 100% after deductible	Covered - 90% after deductible
Rabies treatment after initial emergency room treatment	Covered - 100% after deductible	Covered - 90% after deductible
Chiropractic Spinal Manipulation	Covered - 90% after deductible	Covered - 90% after deductible
	Up to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy		
- Facility and Clinic	Covered - 100% after deductible	Covered - 100% after deductible
- Physician's Office - excludes speech or occupational therapy	Covered - 100% after deductible	Covered - 90% after deductible
	Up to a combined maximum of 60 visits per calendar year	
Durable Medical Equipment	Covered - 90% after deductible	Covered - 90% after deductible
Prosthetic and Orthotic Appliances	Covered - 90% after deductible	Covered - 90% after deductible
Private Duty Nursing	Covered - 90% after deductible	Covered - 90% after deductible
Prescription Drugs	Covered under non-BCBSM contract	Covered under non-BCBSM contract

Hearing Care Program	$10 office visits; more frequent than 36 months if standards met.	
Acupuncture Therapy Benefit - Under the supervision of a MD/DO	Covered - 90% after deductible (up to 20 visits annually)	Covered - 90% after deductible (up to 20 visits annually)
Weight Loss Benefit	Upon meeting conditions, eligible for a lifetime maximum reimbursement of $300 for non-medical, weight reduction.	
Wig, wig stand, adhesives	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of $300. (Additional wigs covered for children due to growth.)	
Deductible, Co-pays and Dollar Maximums		
Deductible	$200 per member; $400 per family	$500 per member; $1,000 per family
Co-pays		
- Fixed Dollar Co-pays - Do not apply toward deductible	$10 for office visits/consultations	
- Percent Co-pays - MH/SA co-pays do not apply toward deductible - Services without a network are covered at the in-network level	10% for MHSA outpatient, chiropractic, durable medical equip., prosthetic and orthotic appliances, and private duty nursing	10% for most services; MHSA at 50%
Annual Dollar Maximums		
- Fixed Dollar Co-pays - Do not apply toward out-of-pocket maximum	N/A	None
- Percent Co-pays - MH/SA and private duty nursing co-pays do not apply toward out-of-pocket maximum	$1,000 per member; $2,000 per family	$2,000 per member; $4,000 per family
Dollar Maximums	$5 million lifetime per member for all covered services and as noted above for individual services	

Appendix H

The following provisions are in effect until October 1, 2002, except for the Group Basic and Major Medical Insurances, as well as the Prescription Drug Plans, which are in effect until January 1, 2003.

Section 1. Life InsuranceSection 1. Life Insurance

A. The Employer shall pay 100% of the employee's premium for the policy, which shall have a death benefit equal to 2.0 times annual salary rounded up to the nearest $1,000.

The employee shall pay 100% of premium for optional dependents' coverage. The employee may choose between three levels of dependent coverage. Effective October 1, 1990 two additional levels of dependent coverage shall become available as described below under "Level 4" and "Level 5":

(1) Level 1 which shall provide a death benefit of $1,500 for the employee's spouse, $1,000 for children from age 6 months to 23 years, and $250 for children from 14 days old but under 6 months.

(2) Level 2 insures spouse for $5,000 and children from age six (6) months to 23 years for $2,500 and children under six (6) months for $250.

(3) Level 3 insures spouse for $10,000 and children from age six (6) months to twenty-three years for $5,000 and children under six (6) months for $250.

(4) Level 4 insures spouse for $25,000 and children age 15 days and over for $10,000.

(5) Level 5 insures children only age 15 days and over for $10,000.

There shall be no age ceiling for handicapped dependents under the optional life insurance plan. Such coverage for handicapped dependents shall be provided at no increased premium cost to the employee. A dependent is considered handicapped if he/she is unable to earn his/her own living because of mental retardation or physical handicap, and depends chiefly on the employee for support and maintenance.

B. In the event of an employee's accidental death in the line of duty, the Employer will pay a death benefit of $100,000, exclusive of what worker's compensation benefit may be owing.

C. Employees covered by the Agreement may enroll for all available employee-paid group life coverage for eligible dependents. Dependent coverage for children shall be the face amount selected beginning for infants at 15 days of age. Employees will be offered these enrollment elections as part of the flexible benefits plan enrollment process.

Section 2. Group Basic and Major Medical Insurance PlanSection 2. Group Basic and Major Medical Insurance Plan

Health Risk Appraisal: Effective in Fiscal Year 1989-90, the Employer agrees to make a Health Risk Appraisal program available, in cooperation with the Department of Civil Service, to Bargaining Unit members who wish to participate. Such program shall consist of a health assessment questionnaire to be completed by the participant, a mechanism for obtaining and recording current clinical data on vital health status measures (e.g., blood pressure, cholesterol levels, height/weight) for each participant, and feedback reports consisting of

individual group profiles. The program shall safeguard participant data from unauthorized release to the Employer, the Union, or third parties. The parties agree to meet and review the State's plans for extending such program to Bargaining Unit members (including a review of the State's experience under a pilot program) prior to its introduction to unit members.

A. The Employer shall maintain the existing group basic and major medical health insurance coverages except as amended herein. The Employer shall pay 95% of the premium for health insurance. The Employer shall provide a hearing care program as part of the basic health care plan. Effective October 1, 1988 when medically appropriate, binaural hearing aids are a covered benefit.

B. Reimbursement for out-patient psychiatric services under Major Medical shall be at 90% with a $3,500 per person maximum benefit per year.

C. Prescription Drug Coverage : From January 1, 1996 through March 31, 1996, the State's Participating Pharmacy (card) plan, shall consist of a non-reimbursable $2.00 subscriber co-payment for each separate prescription.

Such plan provides for an employee identification card and the elimination of the need for employees to process forms for reimbursement when the prescription is filled by a participating provider.

1. Prescription Drug PPO: Effective 4/1/96, Bargaining Unit members will be enrolled in the alternative prescription drug PPO currently administered by Value Rx.

Generic Drugs: The plan shall also provide that, unless otherwise specified by the prescribing physician or the employee, the pharmacy will be required to dispense a generic drug whenever a generic substitution is available. Employees who insist that the prescription be filled with a brand name drug shall communicate this to the dispensing pharmacy. Prescriptions filled by brand name drugs either at the request of the doctor or the employee shall be paid in the same manner as generic drugs.

Effective 10/1/96, the co-payment level on covered prescriptions shall be increased to $7.00 per brand name prescription and $2.00 per generic prescription. Effective January 1, 2000, the co-payment on covered prescriptions shall be increased to $10.00 per brand name prescription and $5.00 per generic prescription. The brand name co-payment level will apply to “DAW” prescriptions. The brand name co-payment will apply when there is no generic substitute.

The brand name co-payments will not apply for drugs with patents scheduled to expire during the period of the contract, but for which

congress has specifically extended the patent protection. When the patent has expired, the brand name co-payment will apply.

The Employer shall implement a mail order prescription drug option for maintenance drugs. At the employee's option, an employee may elect to purchase maintenance prescription drugs through the mail order option. Effective January 1, 2000, there shall be a $10.00 co-pay for brand name drugs and a $5.00 co-pay for generic drugs filled through the mail order option.

D. Effective January 1, 1999, the individual deductible under Major Medical shall be $150.00 per calendar year and the family deductible shall be $300.00 per calendar year. Effective January 1, 2000, the individual deductible under Major Medical shall be $300.00 per calendar year and the family deductible shall be $600.00 per calendar year.

Effective January 1, 1999, the annual "Stop-loss" limit shall be $1,000.00

E. The reimbursement under Major Medical shall be 90%.

F. The Employer shall pay all of the premium if an active employee, his/her spouse or both are eligible for Medicare benefits, in most instances.

G. The Employer shall pay for screening tests of employees, retirees, and their enrolled dependent spouses to assist in early diagnosis of chronic disease. In addition, the following wellness and preventive coverage shall be provided:

1. Mammography in accordance with the latest guidelines recommended by the American Cancer Society (effective 10/1/89).
2. PAP tests annually (effective 10/1/89).
3. Pediatric Well Child Care (effective 10/1/89)
    a. Office visits for Well Baby Care from a child's birth to age 24 months.
    b. Annual office visits for physical examinations for children from age twenty four (24) months to age nineteen (19)
    c. Immunizations and lab testing services from a child's birth to age nineteen (19).
4. The parties agree to include as part of the wellness and preventative coverage in the State Health Plan a Prostate Screening Antigen Test to be administered in accordance with American Cancer Society Guidelines when accompanied by an examination by a physician.

5. Colo-Rectal Screening. Effective October 1, 1999, the State Health Plan will cover routine rectal screening examinations for individuals age 50 and older in accordance with the guidelines of the American Cancer Society.

6. Disease Management Program. Effective October 1, 1999, the Disease Management Program administered by Blue Cross/Blue Shield of Michigan shall be included as a covered benefit on a voluntary basis.

H. The Employer shall pay 95% of premium for enrolled employees who are receiving retirement benefits.

When these retirees qualify for Medicare, the State pays for the full supplemental premium for the retiree and spouse.

I. Group Basic and Major Medical Insurance Plan:
The Employer agrees to continue the Labor Management Health Care Committee.

Each exclusively recognized employee organization shall be entitled to designate one (1) representative to participate in the Plan Labor-Management Committee.

The Management Representatives to the Committee shall be selected by the Employer.

The Plan will consist of four principal components: (1) Pre-certification of all hospital inpatient admissions; (2) Second Surgical Opinion program; (3) Home Health Care; and (4) Alternative Delivery systems.

Effective 10/1/89, the mandatory second opinion program shall be modified as follows: the mandatory second opinion shall be a part of the pre-certification for Hospital Admission benefit. The selected surgical procedures shall remain as listed below. This listing may be changed upon agreement of the parties.

The second opinion referral will be initiated by the provider/physician recommending the surgery at the time the physician contacts the third party administrator for pre-certification for admission. Based upon the medical data provided and the procedure to be done, the physician will be notified if a second opinion is required. If necessary, the employee or dependent will then be contacted to advise him/her of the second opinion requirement and to select a consultant from the panel. The appointment with the chosen consultant will be scheduled for the employee/dependent. The second opinion requirement will be waived when an appointment with an appropriate consultant cannot be scheduled within three weeks or

without excessive travel (over 100 miles). Regardless of the consultant's opinion, the normal surgery payment will be made.

(1) Pre-Certification of Hospital Admission & Length of Stay: The pre-certification for admission and length of stay component of the plan requires that the attending physician submit to the Plan Third Party Administrator for diagnosis, plan of treatment and expected duration of admission. If the admission is not an emergency, the submission must be made by the attending physician and the review and approval granted by the third party administrator prior to admitting the covered individual into the acute care facility. If the admission occurs as an emergency, the attending physician is required to notify the administrator by telephone with the same information on the next regular working day after the admission occurs. If the admission is for a maternity delivery, advance approval for admission will not be required; however, the admitting physician must notify the third party administrator before the expected admission date to obtain the length of stay approval.

(2) Second Surgical Opinion: A mandatory second surgical opinion shall be required for the following types of elective surgery. For purposes of this Article, elective surgery shall be defined as a procedure which may safely be postponed without compromising the employee's health.

: Knee Surgery
: Hysterectomy
: Tonsillectomy and/or Adenoidectomy
: Cholecystectomy
: Inguinal Hernia Repair
: Partial or Complete Mastectomy
: Bunionectomy
: Hemorrhoidectomy
: Excision of Cataracts
: Septo-Rhinoplasty
: Dilation and Curettage
: Varicose Vein Stripping and Ligation
: Prostatectomy
: Laminectomy
: Spinal Fusion

In the event that any of these types of surgery is recommended to the employee or enrolled family member, a second surgical opinion must be sought. The attending physician shall notify the Third Party Administrator when surgery is recommended to an employee or enrolled family member. The Third Party Administrator shall

provide the employee or enrolled family member with a list of 3 or 4 board certified specialists in the covered individual's geographic area. Every reasonable effort will be made to provide this list within 2 - 3 work days. The employee or family member shall select one of the physicians to provide a second opinion. If none of the physicians are able to schedule an appointment for the employee within two weeks, the employee may request a new list from the Third Party Administrator. The physician providing the second opinion shall furnish to the employee and the Third Party Administrator a copy of the diagnosis, prognosis and recommended treatment.

In the event that no board certified specialist is available within 100 miles of the employee's work location, the requirement for a second mandatory opinion will be waived by the Third Party Administrator. If an employee has to drive 50 miles or less one way from the work location to get the second opinion, there shall be no reimbursement. If the employee has to drive 51 - 100 miles one way from the work location to get the second opinion, the employee shall be reimbursed for mileage for any of those miles over 50 one way.

The Plan shall provide full direct payment for the second surgical opinion and necessary tests. Regardless of the outcome of the second opinion, surgical and other expenses for the hospital confinement shall be paid in full up to the current benefit maximum as long as a second opinion was rendered.

Employees may use sick leave, annual leave or compensatory time for mandatory second opinions. Request for such time shall not be denied. Leave used shall not be counted in the consideration of discipline.

Employees may seek a voluntary third opinion. In addition, employees may seek a voluntary second opinion for elective surgical procedures not included on the above list. Upon request, the Third Party Administrator will provide a list of three or four board certified specialists in the covered employee's geographical area. Since such opinions are completely voluntary, they shall be covered under the provisions of the existing health plan. Copies of lists of board certified specialists shall be available in personnel offices and shall be sent to the Union.

An appeal procedure will be established in those cases where there is a difference of opinion between the attending physician and the Third Party Administrator. If an employee feels that his/her doctor

has not adequately presented the case, the employee may present his/her arguments. This employee may be represented by a Union Staff Representative.

(3) Home Health Care: A program of home health care and home care services to reduce the length of hospital stay and admissions shall also be a component of the Plan. This component shall require that the attending physician contact the Third Party Administrator to authorize home health care service in lieu of a hospital admission or a continuation of a hospital confinement.

The attending physician must certify that the proper treatment of the disease or injury would require continued confinement as a resident in-patient in a hospital in the absence of the services and supplies provided as part of the Home Health Care Plan. If appropriate, certification will be granted for an estimated number of visits within a specified period of time. The details of the types of services and charges that shall be covered under this component will be provided in the State Health Care Plan Benefit booklet. Home health care shall be available to employees at their option in lieu of hospital confinement.

(4) Alternative Delivery Systems: The Plan shall also provide coverage for hospice care and birthing center care to employees and enrolled family members. The details of services and charges to be covered for either of these options shall be described in the State Health Care Plan Benefit booklet. Both hospice care and birthing center care shall be available to employees at their option in lieu of hospital confinement.

(5) Health plan coverage for enrolled dependents will cease the 30th day after a unit member's death unless the covered unit member is eligible for an immediate pension benefit from the State Employee's Retirement System.

(6) Payment of Usual, Customary and Reasonable Rates: Effective 1/1/97, covered charges by a provider who is not a participating ("PAR") provider with BCBSM will be reimbursed at the PAR provider UCR rate if 75% or more of the providers of that specialty area of practice in the County in which the member resides are PAR providers. For purposes of this Section, a provider's status as PAR or non-PAR will be established at the beginning of the plan (calendar) year and will be considered unchanged throughout the year.

The member will be responsible for the remaining balance of the billed charges, and this amount will not count toward the member's deductible or stop-loss limit. The joint committee provided for below shall determine what specialty areas of practice will be clustered together for purposes of determining the population of providers upon which the 75% calculation will be made.

Covered charges by a non-PAR provider for a member residing in a county where less than 75% of the providers of that type are PAR providers will be reimbursed at the level of billed charges, less any applicable deductible and co-payment. This does not preclude BCBSM from contracting directly with such provider for a lower fee on specific services.

If a member is under a course of treatment and the provider changes from PAR to non-PAR status, billed charges will be paid, regardless of the percentage of the providers of that type in the county, until that course of treatment has been completed.

The State will arrange for BCBSM to provide information on a quarterly basis on reimbursements under this system to the joint committee provided for in this agreement. In addition to the activities described below, the joint committee will expedite resolution of any problems reported by BCBSM, but nothing will preclude the joint committee from acting on a problem or complaint of an individual prior to receipt of the BCBSM report.

The State and UTEA will arrange for BCBSM to make concerted efforts to increase the number of PAR providers in those areas in which the level of participation is less than 75%, by specialty area of practice. This may include providing additional incentives to providers. In addition, upon request, the state will direct BCBSM to provide letters to members for forwarding to their own physicians (if they are not PAR providers), requesting them to become PAR providers for their own case, if not in full.

J. Substance Abuse Treatment:

The benefits provided by the Health Insurance Plan include the following:

1. Coverage will be provided for substance abuse treatment in licensed facilities for treatment plans not to exceed twenty eight (28) days duration. Treatment plans exceeding twenty eight (28) days will be limited to a maximum of 28 days coverage.
2. Employees will qualify for additional in-patient substance abuse treatment. However, expenses incurred from no more than two admissions per calendar year will be covered.

3. In-patient treatment and charges for room, board and miscellaneous fees will be covered under the basic provisions of the Health Plan as provided below:
    a. Residential Care Facility: 100% of reasonable and customary charges for the standard length treatment program offered by that facility.
    b. Acute Care Hospital Using Acute Care Beds: 67% of semi-private room and board charges and 100% of covered miscellaneous fees for the standard length treatment program offered by that facility. Covered charges for detoxification will be paid at 100% for semi-private room and board and miscellaneous fees.
    c. In the event that the patient's physician requires, as part of the treatment plan, that the patient enter an acute care hospital rather than a residential care facility, requests for payment of more than 67% shall be evaluated on a case by case basis.
4. Covered charges for the out patient care (by an approved provider) of diagnosis, evaluation and treatment of mental and nervous conditions, including drug and alcohol addiction, will be reimbursed under the Major Medical provisions of the health plan. The applicable deductibles and co-insurance will be applied to these charges with a calendar year maximum benefit of $3,500.00.
5. Mental Health/Substance Abuse PPO: Effective 10/1/96 members of the Bargaining Unit will be enrolled in the mental health/substance abuse PPO. If two plans are approved, the UTEA and the Employer will discuss which plan the UTEA members will join. If only one plan is approved, the UTEA members will participate in that plan.
   The current mental health/substance abuse PPO program design is continued during the term of the Agreement.

K. Effective October 1, 1990 the following benefits will be covered under the Group Basic and Major Medical Insurance Plan:
1. Medically necessary orthopedic inserts for shoes will be a covered benefit.
2. Employees meeting "morbid obesity" criteria will be covered by a $300 lifetime weight loss clinic attendance benefit covering those expenses not otherwise generally covered by the Health Plan. "Morbid obesity" is defined as more than 50% or 100 pounds over ideal body weight or 25% over ideal body weight with certain medical conditions (such as diabetes, heart disease, respiratory disease, etc.).
3. The storage cost for self-donated blood in preparation for scheduled surgery will be covered.

L. Subrogation. Effective October 1, 1999, the State Health Plan will contain the following subrogation provision:

"In the event that a participant receives services that are paid by the State Health Plan Advantage (SHPA), or is eligible to receive future services under the SHPA, the SHPA shall be subrogated to the participant's rights of recovery against, and is entitled to receive all sums recovered from, any third party who is or may be liable to the participant, whether by suit, settlement, or otherwise, to the extent of recovery for health related expenses. A participant shall take such action, furnish such information and assistance, and execute such documents as the SHPA may request to facilitate enforcement of the rights of the SHPA and shall take no action prejudicing the rights and interests of the SHPA."

Section 3. Health Maintenance Organization (HMO)Section 3. Health Maintenance Organization (HMO)

As an alternative to the State-sponsored health insurance program, enrollment in an HMO shall be offered to those employees residing in areas where qualified licensed HMO's are in operation. The State shall pay the same dollar value contribution toward HMO membership as is paid to the State-sponsored health insurance program for both employee and employee/dependent coverage.

Section 4. Group Dental Expense PlanSection 4. Group Dental Expense Plan

A. Effective October 1, 1989, a dental "Point of Service PPO" will be implemented.

The parties are assured that employees and dependents enrolled in the State Dental Plan may avail themselves of improved benefit levels at no additional cost to the employee by utilizing dental care providers that are members of the PPO. It has been determined that participation in the PPO will generate savings to the employer and to the employees.

The benefit levels and co-pay levels for specific services are specified in the attached schedule. This point of service PPO plan shall be administered by Delta Dental or any comparable successor dental administrative services only contractor.

B. The Employer shall pay 95% of the applicable premium for employees enrolled in the Group Dental Expense Plan.

C. Permanent-intermittent employees shall be permitted to enroll in the Dental Plan on return from furlough provided they meet other eligibility requirements.

D. Benefits payable under the Dental Expense Plan will be as follows:

90% of actual fee or usual, customary and reasonable fee, whichever is lower, for restorative, endodontic, and periodontic services (x-rays, fillings, root canals, inlays, crowns, etc.).

E. Covered Dental Expenses: The dental expense plan will pay for incurred claims for employee and/or enrolled dependents at the applicable percentage of either the actual fee or the usual, customary and reasonable fee, whichever is lower, for the dental benefits covered under the dental expense plan up to a maximum of $1,000 for each covered person in each twelve (12) month period beginning October 1, 1987 exclusive of orthodontics for which there is a separate $1,500 lifetime maximum benefit.

F. The following services will be paid at the 100% benefit level:

(1) Diagnostic Services:

- Oral examinations and consultations twice in a calendar year.

(2) Preventive Services:

- Prophylaxis -- teeth cleaning three times in a calendar year.
- Topical application of fluoride for children up to age 19, twice in a calendar year; Space maintainers for children up to age 14.
-

G. The following services will be paid at the 90% benefit level:

(1) Radiographs:

- Bite wing x-rays once in a calendar year, unless special need is shown;
- Full mouth x-rays once in a five (5) year period, unless special need is shown.

(2) Restorative Services:

- Amalgam, silicate, acrylic, porcelain, plastic and composite restorations;
- Gold inlay and outlay restorations.

(3) Oral Surgery:

- Extractions, including those provided in conjunction with orthodontic services;
- Cutting procedures;
- Treatment of fractures and dislocations of the jaw.

(4) Endodontic Services:

- Root canal therapy;
- Pulpotomy and pulpectomy services for partial and complete removal of the pulp of the tooth;
- Periapical services to treat the root of the tooth.

(5) Periodontic Services:

- Periodontal surgery to remove diseased gum tissue surrounding the tooth;

- Adjunctive periodontal services, including provisional splinting to stabilize teeth, occlusal adjustments to correct the biting surface of a tooth and periodontal scaling to remove tartar from the root of the tooth;
- Treatment of gingivitis and periodontitis - diseases of the gums and gum tissue.

H. The following service will be paid at the 50% benefit level:
(1) Prosthodontics Services:
- Repair of rebasing of an existing full or partial denture;
- Initial installation of fixed bridgework;
- Initial installation of partial or full removable dentures (including adjustments for 6 months following installation);
- Construction and replacement of dentures and bridges (replacement of existing dentures or bridges is payable when 5 years or more have elapsed since the date of the initial installation).

I. The following service will be paid at the sixty percent (60%) benefit level:
Orthodontic Services:
- Minor treatment for tooth guidance;
- Minor treatment to control harmful habits;
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment;
- Treatment of an atypical or extended skeletal case;
- Post-treatment stabilization;
- Separate lifetime maximum of $l,500 per each enrollee.
- Orthodontic services for dependents up to age l9; for enrolled employee, no maximum age; dependents up to age 25, if the dependent is a full-time student; no maximum age for enrolled spouse.

J. The following service will be paid at the fifty percent (50%) benefit level:
Sealants: Sealants will be covered for permanent Molars only which must be free of restoration or decay at the time of application. Sealants are payable only up to 14 years of age. Payments will be made on a per-tooth basis. No benefit is payable on the same tooth within three years of a previous application. The Dental Plan will pay 50% of the reasonable and customary amount of the sealant with the employee to pay the remainder. Under the dental point of service PPO, the Plan will pay 70% of the charge.

Section 5. Long-Term DisabilitySection 5. Long-Term Disability

A. The Employer shall maintain the existing Group LTD insurance coverage.

B. An employee may elect to enroll in a group plan of income protection in case of total non-work related disability which guarantees income equal to two-thirds of the employee's current basic rate of pay (limited to a maximum payment of $3,000 per month). Payment begins after the use of the employee's accumulated sick leave, but in no event before the fourteenth day of disability. If the employee has fewer than 23 days of accumulated sick leave when first insured, the income guarantee applies for a maximum of two years (Plan I). If the accumulated sick leave is 23 days or more, the guarantee applies until age 65 is reached (Plan II).

Sick leave accumulations are reviewed biweekly. Plan I enrollees who then have more than 23 days of accumulated sick leave are reclassified to Plan II. If the employee has other employment connected or group sponsored income benefits or is receiving Social Security Disability payments, these are included as a part of the two-thirds (66 2/3%) guaranteed income.

C. The Employer shall pay a percentage of premium cost. This percentage varies for individual employees according to applicable plan of insurance coverage.

D. There shall be a no waiting/qualifying period for a recurrence of the same disability within a ninety (90) calendar day period.

E. The Employer shall provide a rider to the existing LTD insurance program. All employees who are enrolled in the LTD insurance program shall automatically be covered by this rider. The rider shall provide insurance which will pay directly to the carrier 100% of health insurance (or HMO) premiums while such employee is receiving LTD insurance benefits for a maximum of six (6) months. The Employer shall pay one-half the cost of such rider and the enrolled employee shall pay one-half the cost of such rider. Effective October 1, 1988 the Employer shall pay the full cost of such rider.

F. All full-time employees, and all permanent intermittent and part-time employees who worked at least 832 hours during the previous fiscal year, are eligible to enroll in the Long-term Disability Insurance program.

Section 6. Insurance Premium While on LayoffSection 6. Insurance Premium While on Layoff

Employees laid off as a result of a reduction in force may elect to prepay the employee's share of premiums for health, dental, life and vision care insurance, for the two (2) additional pay periods after layoff by having such premiums deducted from their last paycheck. The Employer shall pay the Employer's share of premiums for health, dental and life insurance and the vision care plan, for two (2) pay periods for all employees who select this option. Coverage for health,

dental, life and vision care insurance, shall continue uninterrupted for the two (2) pay periods referred to.

Election of this option shall be available only once for employees in a contract year. Permanent employees who do not utilize the entire two pay periods because of recall shall retain this option for full use once in a contract year. Election of this option shall not affect the eligibility of laid off employees to thereafter continue health and life insurance for the remaining thirty five (35) months subsequent to layoff by directly paying the entire premiums therefore in accordance with current practice. Laid off employees shall be eligible to continue vision and dental care insurance for the remaining seventeen (17) months subsequent to layoff by paying the entire premium. This option and the provisions of this Section shall not apply to Department of Mental Health employees who are eligible for severance pay by virtue of layoff due to de-institutionalization.

Section 7. Insurance Premium While on Leave of AbsenceSection 7. Insurance Premium While on Leave of Absence

Employees who are granted a leave of absence may elect, at the time the leave begins, to continue enrollment in the group basic and Major Medical plan (or alternative plan) for eighteen (18) months, dental insurance for eighteen (18) months, vision care insurance for eighteen (18) months, and/or life insurance for up to twelve (12) months by paying the full amount (100%) of the premium.

Section 8. Vision Care PlanSection 8. Vision Care Plan

A. The Employer will provide a Vision Care Plan paying one hundred (100%) of the applicable premium for employees and employee/dependent coverage enrolled in the Plan.

B. Benefits payable for participating providers under the Plan will be as follows:

(1) Examination: Payable once in any twelve (12) month period with an employee co-payment of $5.00.

(2) Lenses and Frames: Payable once in any twelve (12) month period if the employee's eyeglass prescription changes, with an employee co-payment of $7.50 for eyeglass lenses and frames and $7.50 for medically necessary contact lenses.

Effective October 1, 1989 the maximum acquisition cost limit for frames shall be increased from $14.75 to $25.00. The dispensing fee shall remain at $20.00 for a total reimbursement increase from $34.75 to $45.00.

(3) Contact Lenses not Medically Necessary: The Plan will pay a maximum of $40.00 and the employee shall pay any additional

charge of the provider for such lenses. The co-payment provision under (2) is not required.

Effective October 1, 1989 the plan will pay a maximum of $75.00 and the employee shall pay any additional charge of the provider for such lenses.

Effective October 1, 1990 the plan will pay a maximum of $90.00 and the employee shall pay any additional charge of the provider for such lenses.

Medically necessary means: (a) The member's visual acuity cannot otherwise be corrected to 20/70 in the better eye, or (b) the member has one of the following visual conditions: keratoconus, irregular astigmatism, or irregular corneal curvature.

C. Vision Care Plan. Plan payments for non-participating providers:

(1) For Vision Testing Examinations: The Plan will pay 75% of the reasonable and customary charge after it has been reduced by the member's co-payment of $5.00. This benefit will be available once in a twelve month period.

(2) For Eyeglass Lenses: The Plan will pay the provider's charge or the amount set forth below, whichever is less.

(a) Regular Lenses:

Single Vision..... $13.00/Pair

Bifocal..... $20.00/Pair

Trifocal..... $24.00/Pair

(b) Contact Lenses:

Medically necessary as defined in Section B(3) above
$96.00/Pair

Not medically necessary
$35.00/Pair

(c) Special Lenses:

For covered special lenses (e.g. aphakic, lenticular and aspheric) the Plan will pay 50% of the provider's charge for the lenses or 75% of the average covered vision expense benefits paid to participating providers for comparable lenses, whichever is less.

(d) Additional Charges for Plastic Lenses:

Lenses.....$ 3.00/Pair

Plus benefit provided above for covered lenses.

(e) Additional Charges for Tints Equal to Rose Tints:

.....$ 3.00/Pair

(f) Additional Charges for Prism Lenses:

.....$ 2.00/Pair

When only one lens is required, the Plan will pay one-half of the applicable amount per pair shown above.

(3) For Eyeglass Frames: The Plan will pay the provider's charges or $14.00, whichever is less.

Effective October 1, 1989, VDT/CRT operators who, while operating a VDT/CRT, require prescription corrective lenses which are different than those normally used, shall be eligible for reimbursement for lenses and frames on an annual basis at the rates provided herein. Such reimbursement shall be made by the departmental employer. The lenses and frames are in addition to those provided under the vision care insurance. In order to be eligible for this additional reimbursement, employees must utilize a VDT/CRT more than 50% of the time.

(4) The Vision Care Plan will pay for regular lenses up to 71mm as a covered benefit.

Section 9. Qualified 401(k) Tax-Sheltered PlanSection 9. Qualified 401(k) Tax-Sheltered Plan

Employees in this Bargaining Unit shall be eligible to participate in a qualified 401(k) tax-sheltered plan.

Section 10. Flexible Compensation PlanSection 10. Flexible Compensation Plan

The Employer's pre-tax dollar deduction program is extended to unit employees. Under such a program, employee contributions for premiums for health insurance and dental insurance shall be made before FICA and income tax withholding calculations are made.

Effective 10/1/89, employees in this Bargaining Unit will be offered participation in the State of Michigan dependent care and medical spending accounts authorized in accordance with Section 125 of the Internal Revenue Service code.

The parties shall jointly prepare an informational sheet on these programs which will be distributed to employees prior to October 1, 1989.

Section 11. Group Auto/Homeowners InsuranceSection 11. Group Auto/Homeowners Insurance

The State agrees to extend the plan authorized for Non-exclusively Represented Employees to Unit Employees in the event it is successfully re-bid, but no sooner than October 1, 1987.

Section 12. CobraSection 12. Cobra
The parties acknowledge that the Consolidated Omnibus Budget Reconciliation Act of 1985 is applicable to the employees covered by the Collective Bargaining Agreement between the UTEA and the State of Michigan. Therefore, the parties agree that the provisions of the Act shall become applicable to employees and dependents in the Bargaining Unit effective October 1, 1987.

Section 13. Open EnrollmentSection 13. Open Enrollment
Each insurance plan contained in this Agreement shall provide at least one (1) open enrollment period in each fiscal year commencing October 1, 1988.

Section 14. Flexible Benefits PlanSection 14. Flexible Benefits Plan
Effective October 1, 1993, employees in the Technical Bargaining Unit shall be offered the opportunity to enroll in a "Flexible Benefit Plan" as described in the Letter of Understanding titled "Flexible Benefits Plan" appended to this Agreement.

Section 15. Joint Health Care CommitteeSection 15. Joint Health Care Committee
Effective in January 1996, a Joint Health Care Committee is established and will begin meeting on a regular quarterly basis. The purpose of this joint committee is to:

Identify and explore additional managed care initiatives and strategies to reduce or control health care costs and preserve or enhance quality and access to health care services, such as PPOs for radiology services and implementing “Centers of Excellence”; entertain and evaluate and, upon agreement, recommend adoption of, a proposal for an additional State Heath Plan Program Design Option for the flexible benefits program; such joint committee consideration may include benefit design, as well as sharing of premium costs and savings between the Unit’s employees and the State.

Section 16. Group Insurance Premiums for Less than Full-time EmployeesSection 16. Group Insurance Premiums for Less than Full-time Employees
A joint labor-management committee will meet to discuss group insurance premiums for employees working less than full-time. Any proposed agreement shall be subject to review and approval, rejection, or modification by the Civil Service Commission.